Year 2013 Template Objectives for CYSHCN Regional Centers
Legend

A Objective Statement	**D Input Activities G For Your Information**
B Deliverable	**E Base Line for Measurement**
C Context	**F Data Source for Measurement**

1. Brief Contacts

A. By December 31, 2013, (insert number) families with children and youth with special health care needs (CYSHCN), providers, and the general public will receive brief contact services that support the health and wellbeing of CYSHCN from the (insert region) Regional Center for CYSHCN.

B. An End of Year Summary Report, a SPHERE report and analysis of data collected in SPHERE as defined within the Data Source for Measurement to document: the number of families with children and youth with special health care needs (CYSHCN), providers and the general public who received brief contact services that support the health and wellbeing of CYSHCN from the Regional Center for CYSHCN.

C. Acceptable value range for this objective is $50 - $100 for a brief contact for services that support the health and wellbeing of families of CYSHCN, providers, and the general public on behalf of the family, providers in general, and the general public. The MCH and CYSHCN Quality Criteria and Boundary Statement apply. This objective addresses all six CYSHCN National Performance Measures on the individual level. Individual and Household Interventions are set up with an infrastructure that assures timely assistance and interfaces with the broader local, regional and state system of services for children and youth with special health care needs. This work is a core service of every regional center. A Brief Contact is any contact with an individual or family that does not consist of an ongoing relationship. This activity is intended to more completely report significant time spent on professional consultation (not just a short phone call). Since SPHERE is intended to individually list clients, not providers, the brief contact data entry screen is the logical place to report this type of activity. The Regional Center for CYSHCN will provide Brief Contact – Professional Consultation on behalf of professional health care providers.

D. - Provide Brief Contact on behalf of children and youth with special health care needs, their families, providers and the general public.
- Provide Brief Contact Professional Consultation on behalf of professional health care providers.

E.

F. End of Year Summary Report and SPHERE Brief Contact Summary Report to include the data from the following screens: Brief Contact Summary (all appropriate fields including contacted by, activity method, county, program, services, funding, intervention(s), and information/service requested);.
Special note regarding data entry for Professional Consultation on the Brief Contact screen: Within the brief contact screen, select Consultation, fill in time spent and use the Add Note field to list the name of the professional or the name of the organization, i.e., Dr. Paul Johnson or Dean Clinic Pediatrics Department.

2. Information and Referral, Care Coordination

A. By December 31, 2013, (insert number) children and youth with special health care needs (CYSHCN) and their families will receive consultation, referral and follow-up, and/or care coordination from the (insert region) Regional Center for CYSHCN and any subcontracted agencies.

B. An End of Year Summary Report, a SPHERE report and analysis of data collected in SPHERE as defined within the Data Source for Measurement to document: the number of children and youth with special health care needs and their families who received consultation, referral and follow-up, and/or care coordination from the Regional Center for CYSHCN and any subcontracted agencies.

C. Acceptable value range for this objective includes: $100 for consultation services per CYSHCN; $175-$225 for referral and follow-up services per CYSHCN; and $300-$400 for care coordination services per CYSHCN. The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. The CYSHCN National Performance Measure #5 states that Community-based service systems will be organized so families can use them easily. This objective enables families to receive consultation, referral and follow-up, and/or care coordination which in turn will help families secure needed supports. The services are defined by the Minnesota Public Health Interventions framework. Consultation: seeks information and generates optimal solutions to perceived problems or issues through interactive problem-solving with a community, system, family or individual, which the best options are selected and acted upon by the entity. Referral and Follow-up: assists individuals, families, groups, organizations, and communities to utilize necessary resources to prevent or resolve problems or concerns and may include developing resources that are needed, but unavailable to the population. The key to successful referral is follow-up; making a referral without evaluating its results is both ineffective and inefficient. Care Coordination/Case Management: optimizes self-care capabilities of individuals and families and the capacity of systems and communities to coordinate and provide services. Care coordination/case management will be provided as defined and described in the Minnesota Model of Public Health Interventions Manual, including the *Basic Steps for Case Management, Individual/Family Practice Level*, page 95. CYSHCN care coordination/case management is targeted to those CYSHCN and their families that need/request this comprehensive service.

The required data elements for the Children and Youth with Special Health Care Needs Program are contained in the CYSHCN Intake Form, which has the required data elements highlighted.

D.

- Provide consultation services on behalf of children and youth with special health care needs.
- Provide referral and follow-up on behalf of children and youth with special health care needs.
- Provide Health Benefits Assistance as needed; Assist callers in health benefits decisions, problem solving and access to services from birth through the transition to adulthood.
- Collaborate with the Access/Health Benefits Counseling CYSHCN Statewide Initiative related to outreach and referrals.

- Complete the health benefits competency tool annually to identify staff training needs.
- Participate in training and technical assistance provided by the Access/Health Benefits Counseling Statewide Initiative to assure that staff maintain competencies in health benefits knowledge and skills.
- Seek consultation from the Access/Health Benefits Counseling Statewide Initiative for challenging questions.
- Refer families with complex health benefits issues to the Access/Health Benefits Counseling Statewide Initiative and follows-up to assure services were received.

- Maintain a toll-free phone line, accessible walk-in space and center-specific website to provide information, consultation, referral, and follow-up services.
- Utilize and partner with Wisconsin First Step.
- Link parents from Wisconsin screening programs (e.g., newborn hearing, congenital disorders, birth defects, and developmental screening) to support services.
- Participate in and share responsibility for monthly Information and Referral calls.
- Optional Activity: Provide case management interventions for children and youth with special health care needs and complete a care coordination assessment, care plan, ongoing monitoring and evaluation of the activities done within this plan to ensure effectiveness in meeting the child's and family's needs.
- Optional Activity: 1) Administer agreements with Local Public Health Departments and/or Delegate Agencies, during the contract period, to provide referral and follow up and care coordination for children and youth with special health care needs and 2) provide subcontracted agencies with ongoing support and technical assistance to build local capacity within the LPHDs to serve CYSHCN with referral and follow-up.

E.

F. Required data for all interventions provided (consultation, referral and follow-up, and care coordination: End of Year Summary Report and SPHERE Individual/Household Report to include MCH Required Demographic Data, required CYSHCN data elements from the CYSHCN Intake Form and data from the following screens: Intervention: Screening, Subinterventions: Health Care Utilization (all fields) and CYSHCN Transition Assessment (required for ages 14 to 21 years).

Additional data for consultation: Data from the following SPHERE screen: Intervention: Consultation; Subintervention: Health Benefits OR Medical Home

Additional data for referral and follow-up: Data from the following SPHERE screen: Intervention: Referral and Follow-up, Subinterventions: Type/place and outcome.

Additional data for care coordination: Data from the following SPHERE screens: Intervention: Case Management, Subinterventions: CYSHCN Service Coordination/Assessment (all appropriate fields), CYSHCN Care Plan, CYSHCN Ongoing Monitoring; Intervention: Health Teaching, Subintervention: Topic(s) relevant to the services provided under
this objective and Results; Intervention: Referral and Follow-up, Subintervention: Type/place and outcome.

3. Parents as Partners

A. By December 31, 2013, the role of parents as partners in decision making will be strengthened and supported by the (insert region) Regional Center for Children and Youth with Special Health Care Needs.

B. An End of Year Summary Report and SPHERE report as defined within the Data Source for Measurement to document: 1) activities implemented by the (insert region) Regional Center for Children and Youth with Special Health Care Needs that strengthen and support the role of parents as partners in decision making; and 2) outcomes that occurred as a result of implemented activities.

C. The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This is multiyear work focusing on the system changes that impact health outcomes. This objective addresses the CYSHCN National Performance Measures: 1) Families of children with special health care needs will partner in decision making at all levels, and will be satisfied with the services they receive and 2) All families of children with special health care needs will have adequate private and/or public insurance to pay for the services they need. Family Leadership strategies are intended to encourage more partnering in decision making between parents and providers by increasing opportunities for parents to attend trainings, present their family story and bring the parent perspective to systems, councils, boards, and committees. Activities to strengthen individual parents as decision makers and facilitate parent leadership opportunities have long been foundational to the regional center infrastructure.

D.
For activities below, provide details based on agency capacity, funding and regional opportunities. This is ongoing, multiyear work, building on outcomes of previous years.
- Collaborate with the Family Health Leadership Hub CYSHCN Statewide Initiative related to outreach, training, and identification of unmet needs and barriers to services (e.g. Did You Know, Now Your Know training).
- Respond to quarterly requests from Family Voices to add parents to the Family Action Network.
- Partner with the Parent Matching Program to assure that parents are linked to parent-to-parent and other natural support opportunities.
- Collaborate with other entities to provide training for parents of CYSHCN on information and skill-building related to their children (e.g. MCW-HPPW grant).
- Recruit and facilitate linkages for parents of CYSHCN to be partners in decision-making with organizations and systems (internal and external) including the Wisconsin Healthiest Families Initiativefocusing on family supports and Patient at Risk.
- Evaluate system or policy changes that occurred or were achieved as a result of this activity.
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E.

F. End of Year Summary Report and SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the audience focus, and the strategies/outcomes documented in the Results/Outcome field) and either Intervention: Coalition Building, Subintervention: Parent Leadership, Intervention: Community Organizing, Subintervention: Parent Leadership, or Intervention: Collaboration, Subintervention: Parent Leadership.

4. Medical Home

A. By December 31, 2013, local infrastructure building that supports and promotes Medical Home will be implemented by the (insert name) Regional Center for CYSHCN in partnership with the Wisconsin Medical Home Hub Statewide Initiative (WiSMHI).

B. An End of Year Summary Report and SPHERE report as defined within the Data Source for Measurement to document: 1) activities implemented to build the infrastructure that supports and promotes Medical Home; and 2) outcomes that occurred as a result of the implemented activities.

C. The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This is multiyear work focusing on the system changes that impact health outcomes. Many children fall through the cracks due to the lack of a Medical Home. The federal Title V Maternal Child Health Bureau (MCHB) has identified six National Performance Measures and the second one states that all children and youth with special health care needs will receive coordinated ongoing comprehensive care within a Medical Home. Wisconsin was selected as a leadership state by MCHB for its work in Medical Home and efforts to further spread the Medical Home approach are underway.

A State Performance Measure to address the need for a Medical Home for all children is in place as a follow-up to the Title V needs assessment. Wisconsin has a Medical Home Toolkit which has numerous resources for implementing this objective:http://wimedicalhometoolkit.aap.org/. The first step in establishing a Medical Home is to identify the children in the practice that have special health care needs. Evidence-based practice and the American Academy of Pediatrics recommend that early and periodic developmental screening be done on all children. The evidence-based tools for screening will be used and promoted (e.g., ASQ, PEDS) consistent with the American Academy of Pediatrics Developmental Surveillance and Screening of Infants and Young Children policy PEDIATRICS Vol. 108 No. 1 July 2001, pp. 192-195 or http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;108/1/192.

Referral to Parent to Parent is consistent with the American Academy of Pediatrics Family-Centered Care and the Pediatrician's Role Policy Statement PEDIATRICS Vol. 112 No. 3 September 2003 or 08/26/2010 11:18 AM Page 12 of 21 DPH Grants and Contracts. Regional Centers for CYSHCN and local public health departments are in a position to facilitate local capacity building to address these outcomes.

D.

For activities below, provide details based on agency capacity, funding and regional opportunities. This is ongoing, multiyear work, building on outcomes of previous years.

- Collaborate with the CYSHCN Medical Home Statewide Initiative (WiSMHI) to implement and evaluate a regional component of the statewide plan.
    - Outreach to Primary Care Practices within the region for the purpose of educating them on services available from the Regional Center, WiSMHI and othe CYSHCN Partners.
    - Conduct a minimum of 2 Early Identification and Referral (EIR) trainings at Primary Care Practices in coordination with the local B-3 program following format established by WiSMHI, including collection of pre assessments. Materials will be provided by WiSMHI. WiSMHI will do a follow up visit with

practices in coordination the the Regional Center.-Coordinate follow-up and technical assistance requests from local primary care provider practices in coordination with WiSMHI as needed.

- Provide resource information to primary care providers – including information on Parent to Parent of WI, the WI Medical Home Toolkit and other medical home tools and resources identified through WiSMHI.
- Provide information and resources regarding medical home to professionals and families at outreach and training events within the region or at statewide events for which you have lead responsibility..
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E.

F. End of Year Summary Report and SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the audience focus, and the strategies/outcomes documented in the Results/Outcome field) and Intervention: Collaboration, Subintervention: Medical Home.

5. Outreach and Partnerships

A. By December 31, 2013, a regional outreach and partnership plan will be implemented to support a coordinated system of services for CYSHCN and their families by the (insert name) Regional Center for CYSHCN.

B. An End of Year Summary Report and SPHERE report as defined within the Data Source for Measurement to document: 1) the CYSHCN Regional Center outreach and partnership plan; 2) strategies implemented from the plan to support a coordinated system of services for; 3) outcomes that occurred as a result of the implemented strategies.

C. The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This is multiyear work focusing on the system changes that impact health outcomes. This objective addresses the CYSHCN National Performance Measure: Community-based service systems will be organized so families can use them easily. Regional Centers for CYSHCN hold an enormous amount of expertise through their highly qualified staff, dedication to quality and extensive resources. There is a need to assure that internal and external partners recognize and value that expertise. Regional Centers need to foster relationships with their internal organizational leaders and external CYSHCN partners so that more families can ultimately know about and have access to the supports and services that may improve the quality of their lives.

D.

For activities below, provide details based on agency capacity, funding and regional opportunities. This is ongoing, multiyear work, building on outcomes of previous years.

- Review and update the outreach and partnership building plan that identifies key CYSHCN stakeholders and partnerships for this contract year. (e.g., WI Early Childhood Collaborating partners and its' committees, Local Health Departments working on the Wisconsin Healthiest Families Initiative, Birth-3, Children's Long Term Supports, Aging and Disability Resource Centers, transition-related groups, WIC/Nourishing Special Needs, Oral Health,

Children's waiver, Family Support, Genetics Services, and new CYSHCN grant opportunities).
-Identify strengths, gaps and opportunities to improve the outreach and partnership building plan.
-Implement strategies to strengthen and improve outreach and partnerships.
- Provide CYSHCN expertise for regional trainings and technical assistance for local agencies.
- Establish and build the capacity of your organization to respond to regional opportunities and needs to support this objective.
- Identify pressing issues, exchange information and resources, gather local input regarding unmet needs, enhance the understanding of the multiple services available in the region, disseminate information to regional stakeholders on key issues, and build relationships between partners.
- Facilitate CYSHCN representation on local WHFI teams.
- [Insert other strategies identified by the Regional Center.]
-Evaluate outcomes that occurred as a result of the implemented strategies.

E.

F. End of Year Summary Report and SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the goals and objectives and partners documented in the results/Outcome field) and Intervention: Collaboration, Subintervention CYSHCN Partnership.

6. Transition
A. By December 31, 2013, he transition of youth from childhood to adult life will be supported and promoted with an emphasis on health related services by the (insert region) Regional Center for Children and Youth with Special Health Care Needs in partnership with the Youth Health Transition Hub Statewide Initiative.

B. An End of Year Summary Report and SPHERE report as defined within the Data Source for Measurement to document: 1) activities implemented to support and promote the transition of youth from childhood to adult life with an emphasis on health related services and 2) outcomes that occurred as a result of the implemented activities.

C. The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This is multiyear work focusing on the system changes that impact health outcomes. This objective addresses the CYSHCN National Performance Measure: All youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. This objective builds on groundwork of the statewide Community of Practice on Transition which includes a broad spectrum of stakeholders, which establishes a forum for information exchange, networking and addressing emerging issues. Regional Centers for CYSHCN need to connect to this statewide initiative in order to promote and facilitate YSHCN transition on the regional and local levels. This group has a Practice Group on Health which accomplishes shared work and each regional center commits to sending a representative to this workgroup.

D.
For activities below, provide details based on agency capacity, funding and regional opportunities. This is ongoing, multiyear work, building on outcomes of previous years.

- Partner with the Youth Health Transition Statewide Initiative by disseminating recruitment information/training opportunities, share transition needs with statewide, and utilize information provided by the statewide.
- Participate in technical assistance calls that the Youth Health Transition Statewide Initiative may host on relevant transition issues
- Stay current on health transition and the activities of the Community of Practice on Transition and engage in the Practice Group on Health.
-Collaborate with Family Voices of Wisconsin on Youth Transition training as applicable.

E.

F. End of Year Summary Report and SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the strategies documented in the Results/Outcomes, and include the Intervention: Collaboration with the Subintervention Youth Leadership.